

Division of Licensing and Protection  
103 South Main Street  
Waterbury, VT 05671-2306  
<http://www.dail.vermont.gov>  
Voice/TTY (802) 871-3317  
To Report Adult Abuse: (800) 564-1612  
Fax (802) 871-3318

April 10, 2015

Mr. Dennis Beauregard, Administrator  
The Residence At Shelburne Bay West  
185 Pine Haven Shore Road  
Shelburne, VT 05482-7805

Dear Mr. Beauregard:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **March 9, 2015**. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,



Pamela M. Cota, RN  
Licensing Chief

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  0589	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	Licensing and Protection	(X3) DATE SURVEY COMPLETED  C 03/09/2015
NAME OF PROVIDER OR SUPPLIER  THE RESIDENCE AT SHELburne BAY WEST		STREET ADDRESS, CITY, STATE, ZIP CODE 185 PINE HAVEN SHORE ROAD SHELburne, VT 05482			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
R100	Initial Comments:  An unannounced on-site survey to investigate a complaint and a facility mandatory self-report was completed on 3/9/15 by the Vermont Division of Licensing and Protection. The following regulatory violation was found.	R100			
R179 SS=D	V. RESIDENT CARE AND HOME SERVICES  5.11 Staff Services  5.11.b The home must ensure that staff demonstrate competency in the skills and techniques they are expected to perform before providing any direct care to residents. There shall be at least twelve (12) hours of training each year for each staff person providing direct care to residents. The training must include, but is not limited to, the following:  (1) Resident rights; (2) Fire safety and emergency evacuation; (3) Resident emergency response procedures, such as the Heimlich maneuver, accidents, police or ambulance contact and first aid; (4) Policies and procedures regarding mandatory reports of abuse, neglect and exploitation; (5) Respectful and effective interaction with residents; (6) Infection control measures, including but not limited to, handwashing, handling of linens, maintaining clean environments, blood borne pathogens and universal precautions; and (7) General supervision and care of residents.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the	R179	R179  All direct caregivers receive 12 hours of training each year and training will include regulatory required topics. All training records for 2015 will be audited for compliance with inservice completion. Caregivers that have not completed required inservices will be contacted to complete. Inservice education was provided to all associates on the steps to take in the event that a resident falls. This information was provided to associates in the form of a communication memo and at an associate Care meeting held on 2/23/15.  The staffing educator will monitor the inservice training records on a monthly basis to ensure compliance.  Any associate lacking required inservice will be scheduled to complete.  This corrective action will be completed by May 15 <sup>th</sup> , 2015.  R179 Poc accepted 4/9/15 MBdton P-N/PMC		

Division of Licensing and Protection  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Division of Licensing and Protection

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R179	Continued From page 1  home failed to assure that each staff member providing direct resident care completed the mandatory trainings specified in the Residential Care Home (RCH) Licensing Regulations, effective 10/3/00 for 1 of 5 employees in the total sample. Findings include:  Per review of a sample of 5 employee personnel records for evidence of Vermont RCH mandated annual trainings, 1 of 5 employees had failed to complete the annual training for Resident Rights and Resident Emergency Response Procedures/first aid. This was confirmed during interview with the Director of Nursing Services (DNS) on 3/9/15 at 3:45 PM. The employee who did not complete these trainings had also failed to follow facility procedures after finding a resident on the floor and complaining of pain on 2/22/15. The staff member moved the resident without direction from the nurse who had been called to the unit check for any resident injuries, thus placing the resident at risk of further injury. The DNS (Director of Nursing Services) stated that when care givers find a resident on the floor and voicing complaints of pain, they are instructed to call the nurse and receive further directions on how to proceed. The staff member was re-educated the following day.	R179		